VA NATIONAL CENTER ON HOMELESSNESS AMONG VETERANS

Promoting data-driven, evidence-based solutions to end Veteran homelessness

HOMELESS EVIDENCE AND RESEARCH SYNTHESIS (HERS) ROUNDTABLE PROCEEDINGS

Rural Veterans and Homelessness

June 22, 2017

Homeless Evidence and Research Synthesis (HERS) Roundtable Series

The National Center on Homelessness among Veterans (the Center)in the Veterans Health Administration (VHA) established the Homeless Evidence and Research Synthesis (HERS) Roundtable Series in 2015 as a policy forum. The virtual symposium convenes researchers and subject matter experts to discuss research findings on key issues in homelessness. The online webinar is available to interested parties within and outside of the U.S. Department of Veterans Affairs (VA). Topics covered to date include: **Enumeration of Homelessness** (July, 2015), **Aging and the Homeless Community** (November, 2015); **Women Veterans and Homelessness** (May, 2016); **Opioid Use Disorder and Homelessness** (February 2017); and **Rural Veterans and Homelessness** (June, 2017). Links to the recorded webinars and proceedings are available on the Center website.
https://www.va.gov/HOMELESS/nchav/research/HERS.asp

Rural Veterans and Homelessness

The Rural Veterans and Homelessness Proceedings are a summary of the presentations and roundtable discussion that took place on June 22, 2017 in a virtual symposium. The recorded webinar and downloadable copies of the individual presentations are available here http://va-eerc-ees.adobeconnect.com/p4nd85ke01z2/.

Presenters

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Alan West, PhD, Health Scientist, VHA Office of Rural Health

Stephen Metraux, PhD, Researcher, VA National Center on Homelessness among Veterans

Dorota Szymkowiak, PhD, Researcher, VA National Center on Homelessness among Veterans

Debra Baker, LMHC, Director, Supportive Services for Veteran Families, Blue Mountain Action Council

Linda J. Southcott, Deputy Director, VA Supportive Services for Veteran Families National Program Office

Roundtable Panel

Roger Casey, PhD, LCSW, Director of Education and Dissemination, VA National Center on Homelessness among Veterans

David Corwin, Housing Programs Director, Pennsylvania Rural Development, U.S. Department of Agriculture

Keith Harris, PhD, National Director of Clinical Operations, Veterans Health Administration Homeless Programs

Tom Klobucar, PhD, Acting Director, Office of Rural Health, Veterans Health

Kathryn Monet, Executive Director, National Coalition on Homeless Veterans

Planning Committee

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Rebecca Watkins, Pennsylvania Rural Development, U.S. Department of Agriculture
Alan West, PhD, VHA Office of Rural Health
Barbara Wortman, National Center on Homelessness among Veterans

Executive Summary

When the initiative to eliminate Veteran homelessness was launched in 2009, the response was focused in urban areas, where the problem was most visible. But poverty and housing instability are major issues in rural settings. What do we know about Veterans living in rural areas? What are their particular needs and challenges, and how is the VA addressing them? Do approaches that work in urban areas translate to the rural environment? What models should we adopt or develop to improve access to services for rural Veterans experiencing housing instability? Which existing programs should we enhance?

The National Center on Homelessness among Veterans (the Center) in the Veterans Health Administration (VHA) convened VA researchers and a roundtable panel that comprised key stakeholders from the VHA Homeless Program Office and Office of Rural Health, the U.S. Department of Agriculture, and the National Coalition for Homeless Veterans to present what we know about these issues and consider the challenges and opportunities before us.

Dr. Ann Elizabeth Montgomery provided an overview of homelessness in the rural context, including definitions of rurality and the difficulty of accurately estimating the number of Veterans experiencing homelessness. Dr. Alan West described the challenges rural Veterans encounter in accessing health care and the collaborative approach that VA is taking to address these issues. Drs. Stephen Metraux and Dorota Szymkowiak compared the demographics and use of VHA Homeless Programs among rural and non-rural Veterans. Debra Baker, who represents a VA Supportive Services for Veteran Families (SSVF) provider operating in rural Idaho, Oregon, and Washington, used case studies to illustrate the considerable individual and operational challenges of responding to the needs of Veterans experiencing housing instability in rural areas.

Almost one-quarter of Veterans live in rural areas compared with 18% of all Americans. More than three million use VHA care and are more likely than their urban counterparts to be White, married, have lower education and income, and poorer health. Rural homelessness is often invisible, difficult to assess, and underestimated. The *Annual Homeless Assessment Report to Congress* estimates that 5,294 Veterans were homeless in rural areas during one night in January 2016, 41% of whom were unsheltered. The nature of housing crises experienced by Veterans in rural areas may be different from their urban counterparts. Evidence suggests that Veterans in rural areas are less likely than those in urban areas to experience literal homelessness**,** and instead may face a greater risk of housing challenges related to residential mobility and adequacy, availability, and accessibility of housing stock.

During FY 2014, 2,172 Veterans located in a rural zip code were assessed for entry into a VHA Homeless Program; an additional 4,637 screened positive for housing instability at rural VA Medical Centers (VAMCs) or Community-Based Outpatient Clinics (CBOCs). VA staff serving Veterans at rural CBOCs have identified substance use, mental illness, and lack of employment as rural Veterans' primary causes of homelessness. VHA Homeless Programs have a presence in rural communities to address these needs: 7.3% of transitional Grant and Per Diem (GPD) beds are located in rural areas and almost one-half of SSVF grants to provide homelessness prevention and rapid rehousing were awarded in rural areas. Nonetheless, access to homeless services is challenged by distance, lack of transportation, and housing assistance provider shortages. A sample of more than 200,000 Veterans who used a VHA Homeless Program between FY 2013 and 2016 showed that 70% of the rural Veterans who accessed VHA Homeless Programs did so in non-rural areas.

The roundtable panel and presenters stressed the need for additional research specific to the needs of rural homeless Veterans and enhanced partnership and collaboration with government and community-based partners to develop solutions to the particular challenges of the rural environment.

Homelessness in the Rural Context

Ann Elizabeth Montgomery, PhD

Defining rural areas

Rural areas are classified using a number of approaches, based largely on population size or density and land use;[1-4] depending on the criteria used to categorize rural and urban spaces, 72% of the country's land mass is rural, and rural areas are home to approximately 15% of the country's population.[4]

Differences between rural and urban residents

Compared with people living in urban areas, rural residents tend to be older, married, and residing in the state of their birth. Rates of unemployment are higher and incomes are lower in rural areas. Rural residents are more likely to own their homes;[5] however, the quality and value of housing in rural areas are low, housing instability is common,[6] and there is the ongoing challenge of residential mobility.[7] Rurality has been identified as a significant contributor to health disparities[8] due to in large part to lack of access to services.[9-11] In particular, there is a dearth of specialized services to address needs related to mental health and substance use.[9,11-13]

Challenges to identify and serve people experiencing homelessness in rural areas

It is difficult to accurately estimate the size of the problem of rural homelessness due to its invisibility,[10,14-16] the limited availability of services intended to respond to homelessness,[9,14,16] and the inadequacy of the definition of homelessness[16,17] and counting methods typically used in urban environments.[18] The migration of people experiencing housing instability from more to less rural areas likely leads to an underestimate of the size of the rural homeless population.[11,13,15,19] Point-in-time counts conducted in the more rural balance-of-state and statewide Continuums of Care (CoCs) indicate that approximately one-half of the country's homeless population resides in areas other than the 50 largest cities, accounting for more than 75,000 people, one-third of whom were staying in unsheltered situations.[i] [23]Rural areas often do not have sufficient resources to address housing crises[13,20] and the rural environment makes it difficult to implement evidence-based responses such as rapid rehousing.[10]

Homelessness among rural Veterans

Almost one-quarter of Veterans live in rural areas compared with 18% of all Americans.[21] More than one-half of rural Veterans are older than 65 years and 40% have a service-connected disability;[21] however, they more frequently have access to health insurance compared to their non-Veteran counterparts.[1] Rural Veterans using VHA care most often identify as White, report lower levels of education and being married, and have lower income than their urban counterparts.[22] The *Annual Homeless Assessment Report to Congress* estimates that 5,294 Veterans were homeless in balance-of-state CoCs during one night in January 2016.[23] During FY 2014, 2,172 Veterans located in a rural zip code were assessed for entry into a VHA Homeless Program; an additional 4,637 screened positive for housing instability at rural VA Medical Centers (VAMCs) or Community-Based Outpatient Clinics (CBOCs).[24] VA staff serving Veterans at rural CBOCs have identified substance use, mental illness, and lack of employment as rural Veterans' primary causes of homelessness.[25] VHA Homeless Programs have a presence in rural communities to address these needs: 7.3% of transitional Grant and Per Diem (GPD) beds are located in rural areas and almost one-half of SSVF grants to provide homelessness prevention and rapid rehousing were awarded in rural areas.[24]

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[i] Throughout the United States, homeless services are organized around 399 continuums of care (CoC), which are further categorized by geographic type. Major city CoCs are located in the 50 largest cities in the United States and comprise 49.3% of the homeless population nationally. The second type of CoC is comprised of smaller cities, counties, or regions that are not part of a major city or the remaining balance of state CoCs; these CoCs comprise 36.8% of the homeless population nationally. Finally, balance of state (BoS) CoCs comprise multiple rural counties in a state while statewide CoCs include an entire state; this category of CoCs comprises 13.9% of all homeless people.

Rural Veterans and Access to VA Health Services

Alan West, PhD

VHA Office of Rural Health's strategies to increase access to health care

The VHA Office of Rural Health (ORH) focuses on increasing access to health care for the 3 million Veterans living in rural communities who are enrolled in VHA. To combat the problems of an aging population, provider shortages, and long distances to clinics and hospitals, ORH supports more than 50 Collaborative Rural Access Solutions or Rural Promising Practices, which have been adopted at three-quarters of VA medical centers around the country, impacting more than 570,000 Veterans.

Collaborative Rural Access Solutions

Collaborative Rural Access Solutions expand the delivery of existing VA health services in primary and specialty care, mental health, and transportation into rural settings. Solutions include increasing staffing and using telehealth to provide expert clinical consultation and care to patients at CBOCs or in-home care. It is important to note that limited broadband coverage and Internet access may make telehealth options inaccessible for rural Veterans. There is interest in collaboration between ORH and VHA Homeless Programs to develop interventions to better identify and serve rural Veterans experiencing housing instability. A partial list of Collaborative Rural Access Solutions appears below.

Increasing Access to Clinical Pharmacy Specialist Providers for Rural Veterans
Military Sexual Trauma Web-Based Therapy
Tele-Primary Care
***My*VA Access**
National Teleradiology Program
Precision Oncology Program
Rural Expansion of Home-Based Primary Care
Rural Expansion of Medical Foster Home
Rural Expansion of Social Work in Patient Aligned Care Teams
National Telemental Health Center
Rural Health Training Initiative
Rural Provider and Clinical Staff Training Initiative
Telemental Health Hubs
Rural Tele-Stroke Emergency Care
Rural Veteran Transportation Services
Simulation Learning, Education and Research Network (SimLEARN) Rural Coordinators
VA Extension for Community Healthcare Outcomes (ECHO) Transgender Curriculum
State Veterans Homes Telehealth Initiative
Support for Caregivers of Veterans
Teledermatology
Telephone Lifestyle Coaching
VA Innovators Network
Vets Prevail Web-Based Behavioral Support
Tele-Intensive Care Unit

Rural Promising Practices

Rural Promising Practices are new programs that originate through ORH's three rural health resource centers. Implemented through mentored support, they include:

- Clinical Video Telehealth Comprehensive Care to Veterans with Multiple Sclerosis
- Community Clergy Training to Support Veterans' Mental Health
- Connecting Older Veterans (Especially Rural) to Community or Veteran Eligible Resources
- Geriatric Scholars Training Program
- Remote, Home-Based Delivery of Cardiac Rehabilitation
- Telehealth Collaborative Care for Rural Veterans with HIV Infection

While many rural enrollees use both VA and non-VA care, they are more likely to consider VA their primary source of care and to rely on it more, even though they travel farther to receive it. This speaks to a need to coordinate enrollees' VA and non-VA use to optimize care and to provide prevention and wellness services to foster Veterans' well-being.

Characteristics and Service Use of Rural Homeless Veterans

Dorota Szymkowiak, PhD & Stephen Metraux, PhD

Overview

Drs. Metraux and Szymkowiak presented some preliminary results, based upon VA homeless services and health care data, on differences between rural and non-rural homelessness. Rural Veterans comprised 15% of the 210,164 homeless Veterans who used a VHA Homeless Program between FY 2013 and 2016. They were more frequently White and younger than their non-rural counterparts.

Diagnoses and health care services use

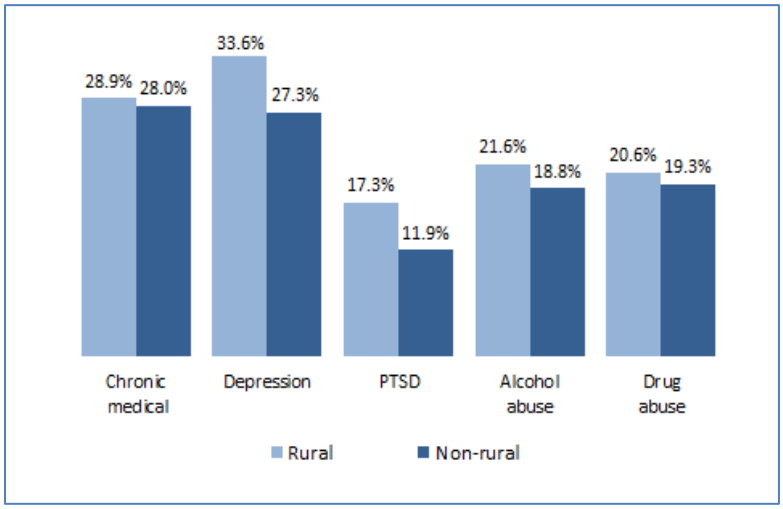

Figure 1. Diagnoses

Levels of chronic disease diagnosis were roughly equal between rural and non-rural homeless Veterans, however, rural homeless Veterans had significantly higher rates of behavioral health diagnoses (Figure 1). Lower proportions of rural homeless Veterans used most types of healthcare services, except for higher proportions who used behavioral health (substance abuse and mental health) services (Figure 2).

Service	Rural (N=29,865)	Non-rural (N=169,793)
Inpatient	16.7%	16.7%
Medical	7.9%	9.0%
Mental health	6.7%	5.8%
Substance use	5.1%	4.7%
Emergency Department	34.5%	41.2%
Outpatient		
Primary care	76.2%	77.0%
Specialty medical	71.2%	73.0%
Mental health	65.6%	59.6%
Substance use	28.4%	26.6%

Figure 2. Health Care Services Use

VHA Homeless Programs use

Higher proportions of non-rural Veterans used almost every VHA Homeless Program, especially programs like GPD, Health Care for Homeless Veterans, and HUD-VA Supportive Housing (HUD-VASH), likely due to geography and access issues. The most prominent exception is the use of Domiciliary Care for Homeless Veterans; these facilities are often located on more rural VA campuses and more rural Veterans, proportionately, make use of these services (Figure 3).

Programs	Rural (N=30,919)	Non-rural (N=179,245)
Health Care for Homeless Veterans (HCHV)	76.4%	83.3%
Supportive Services for Veteran Families (SSVF)	34.6%	41.5%
Transitional/short-term housing	46.4%	54.7%
Domiciliary Care for Homeless Veterans (DCHV)	11.7%	8.7%
Contracted Emergency Residential Services (CERS)	17.1%	19.1%
Grant and Per Diem (GPD)	28.6%	40.5%
HUD-Veterans Affairs Supportive Housing (HUD-VASH)	55.3%	62.5%
Case management only	33.8%	30.5%
Housing	21.5%	32.0%
Services for justice-involved Veterans (HCRV, VJO)	20.4%	17.8%

Figure 3. VHA Homeless Programs Use

Migration of rural homeless Veterans to urban areas

Seventy percent of the rural Veterans who accessed VHA Homeless Programs did so in non-rural areas; however, virtually none of the Veterans experiencing homelessness in non-rural areas used rurally-located services. This may be an indicator that rural Veterans are migrating to more urban areas to access VA services. This is consistent with a preliminary study looking at migration patterns among Veterans experiencing homelessness, done by Dr. Metraux, which suggested that there was more geographic mobility among homeless Veterans in smaller, more rurally based VAMC catchment areas.

Key Findings

- Rural homeless Veterans had higher levels of behavioral health diagnoses and related services and lower levels of other VA health care services. They appear to often access these services at urban locations.
- Rural homeless Veterans accessed VA homeless services less frequently, possibly a reflection of fewer homeless services in rural areas and less willingness to migrate to more urban areas to access these services.
- The phenomenon of homeless Veterans traveling from rural to urban areas for services, be it for homelessness or health care, is poorly understood. Research is needed on whether urban-based homeless services adequately address the needs of rural homeless Veterans.

Rural Veterans and Homelessness: A VA Supportive Services for Veteran Families (SSVF) Provider's Perspective

Linda Southcott & Debra Baker, LMHC

SSVF overview

Since 2012, VA has granted funds through the SSVF program to community partners throughout the country to rapidly rehouse homeless Veteran families and to prevent homelessness for those experiencing a housing crisis. Grantees provide outreach, case management services, assistance in obtaining VA and other public benefits, and temporary financial assistance for moving costs, security deposits, rent, transportation, child care, and legal fees. As the program has grown, SSVF has expanded services to more rural areas each year. During FY 2017, 60% of the 367 active SSVF programs serve both urban and rural communities and 13% support rural communities exclusively.

Among a sample of 85 SSVF grants made during FY 2016, financial assistance was provided less frequently to *literally homeless* Veterans and families in rural areas (57.2%) compared to those in urban locations (66.2%); however, a greater proportion of Veterans *at risk of homelessness* in rural areas received financial assistance (42.8%) compared to Veterans in urban locations (33.8%).

SSVF in rural areas: challenges and effective practices

Figure 4 presents the challenges and effective practices for serving rural Veterans experiencing homelessness based on work in 17 rural counties in southeast Washington, central Idaho, and northeast Oregon.

Challenges	Effective Practices
Operational	
▪ Community coordination and building capacity (ex. few Veteran leadership teams, less formal partnerships) ▪ Accurate 'counting' and data ▪ Limited availability of services related to housing and health care ▪ Transportation	▪ Staff cover multiple counties, even more small towns ▪ Get to know the "movers and shakers" and reach out to wider group of partners ▪ Open door for coordinated entry and open to less typical service providers (many businesses and faith-based) ▪ Use a combined approach of centralized service location for general intake/provision, specialized services, and mobile services
Individual	
▪ Isolation and seasonal impact ▪ Substandard housing or "under housed" ▪ Transportation ▪ Needs related to multiple-person families versus single-person families	▪ Cultural competence when working with those who may 'prefer' isolation or feel cut off from community ▪ Prepare for seasonal inflow (where they are coming from, timing to engage before they leave again) ▪ Offer of services not given all at once and use best resources (small towns talk!)

Figure 4: SSVF in Rural Areas: Challenges and Effective Practices

The following case studies of a World War II Veteran and a young female combat Veteran of Operation of Iraqi Freedom brought to life the facts and statistics presented earlier in the symposium by the researchers.

*"**Darwin**," a Veteran of World War II, was 92 years old and sleeping at night in a small town post office in Idaho when SSVF first met him. No agencies were able or willing to take his case. His personal challenges included dementia, alcohol use disorder, and estrangement from his six children. The operational challenges were lack of appropriate housing and services for the elderly, as well as the 67 miles between him and his SSVF case worker. Initially, SSVF placed Darwin in two different assisted living facilities, but he fled both, wanting his independence. Subsequently, his case manager found him a small house and obtained a Representative Payee Service with the help of his doctor and the Social Security Administration. SSVF paid the security deposit and the first and second months' rent. People in the community were looking after him and it was determined he no longer needed SSVF.*

However, a year later SSVF learned that Darwin was in a nursing facility in a nearby town. After a few months they were notified that he had been admitted to the local hospital. He had been forced out of his house by someone who had been exploiting him and was sleeping on the street. The SSVF case manager visited Darwin at the hospital and worked with the discharge planner to identify an attorney and a social worker to set up a guardianship. SSVF paid the legal fees for this arrangement and Darwin was placed in a nursing home.

The key to this success story is Darwin's case manager, a Veteran who lived locally and was able to build trust and a rapport with him. She knew how to get things done in the community, to connect with the "movers and shakers" and build support networks. When she closed Darwin's case the second time, he gave her his personal handwritten journal and photos from his war service.

***"Mary"** called the SSVF office last winter. An Operation Iraqi Freedom combat Veteran, pregnant with her fourth child, she had recently left her husband and was living with her mother and three children in a small rural community in Oregon. The children had transitioned well in a new school and at home with their grandmother but the number of people in the dwelling violated the lease agreement. Mary had very low income, receiving 30% service connected disability. One of her children was severely disabled and another had an allergy that only allowed for dairy from goats. Mary was raising goats and chicken for food and kept pet dogs.*

SSVF connected Mary to the local Veteran Service Organization who helped her to qualify for 100% service connected disability due to PTSD. Although it took some time, Mary and SSVF were able to secure affordable housing that would accommodate the animals and keep the children in the same school. SSVF helped Mary with the security deposit and first month's rent and bought her a bed.

Once again, the SSVF case manager was critical to the happy outcome for the Veteran. As a Veteran himself, he connected with Mary, understanding the military culture where a "hand up" is better accepted than a "hand-out." He respected her desire to stay near her mother and to keep the family animals, a common situation in rural areas. He also successfully connected with the local community, 76 miles from his office, getting to know people in the coffee shop, to find out what the local resources were. In rural America, the SSVF case manager has to "do it all."

Panel Discussion and Recommendations

The roundtable discussion, moderated by Dr. Roger Casey, included leaders and researchers from the VHA Homeless Program and Office of Rural Health, the U.S. Department of Agriculture, and the National Coalition for Homeless Veterans. Their recommendations are listed below.

Consider alternative definitions of homelessness in the rural context

- Dr. Montgomery highlighted the connection between housing insecurity and the pervasiveness of poverty in rural areas. Given the suggestion that there is a false distinction between rural poverty and homelessness,[26] it is important to consider the inclusion of poverty as part of a broader definition of *housing insecurity* in rural areas.

Standardize measures of "rural" as applied to VA and homelessness

- Dr. Montgomery noted, and Drs. Szymkowiak and Metraux encountered, different and inconsistent measures in distinguishing rural and non-rural areas based on VA data, making it difficult to develop clear geographical classifications for homeless Veterans.

Assess the needs of Veterans who are reintegrating in rural communities following military service

- Dr. Montgomery stated that Veterans returning to their rural communities following military service may require additional resources to assist in their reintegration due to lack of services or other barriers to care, raising the issue of homelessness prevention. Dr. Klobucar referenced the successful Rural Veterans Coordination pilot program, which provided grants to state and local governments and non-profit organizations to assist OEF/OIF Veterans to transition to civilian life.

Improve approaches to identify and engage rural homeless Veterans who are frequently under-counted and "invisible"

- Dr. Harris suggested that the VHA Homeless Program Office take a leadership role with HUD to adapt the effective urban practice of developing a "by name list" of rural Veterans experiencing homelessness and coordinating and prioritizing their entry into homeless programs and services. This strategy would require dividing very large geographic spaces—in some cases, entire states—into manageable areas where resources and information may be shared across organizations.
- Ms. Monet advocated for direct people-to-people contact. She indicated that many member organizations of the National Coalition for Homeless Veterans have included Veterans in their outreach efforts and have found word-of-mouth effective in connecting Veterans to resources. Partnering with Veterans Treatment Courts also helped to engage Veterans with services. A pilot program conducted by the Washington State Department of Veterans Services, through the Department of Labor's Homeless Veterans Reintegration Program, called Veterans to survey their needs and connected many of them to services about which they were previously unaware.
- Dr. Klobucar highlighted the expansion of an initiative that shows great promise for engaging Veterans experiencing homelessness in rural areas: the Enhanced Rural Access Network for Growth Enhancement (E-RANGE). The program provides intensive case management and outreach services for Veterans with serious mental illness. It has proven to be effective and has been adopted by many medical centers in rural areas.
- Dr. West recommended that HPO and ORH collaborate to better identify and serve rural Veterans experiencing housing instability. Drs. Klobucar and Casey agreed that ORH Rural

Consultants and HPO Network Homeless Coordinators could explore ways to coordinate their efforts.

Identify strategies to ensure that Veterans experiencing chronic housing insecurity in rural areas have access to resources

- Drs. Metraux and Szymkowiak pointed out that there is little known on the extent to which urban-based homeless services adequately address the needs of rural homelessness. Rural Veterans seem to be accessing homeless services in more urban locations, but use homeless services at lower rates than non-rural Veterans. Little is known about the impact of access to services on rehousing and whether lack of access encourages migration or makes Veterans less likely to engage in services. If there is a need for homeless services that can better reach and serve Veterans in rural areas, what would those services look like?
- Dr. Montgomery recommended organizing existing VHA Homeless Programs resources in a way that could be more responsive to the needs of rural Veterans, including co-locating them with CBOCs. Virtual methods to address housing insecurity may need closer consideration given that 43% of rural Veterans do not have internet access at their homes.[27]
- Both Mr. Corwin and Ms. Monet advocated for helping rural Veterans to stay in their communities by improving their housing through weatherization, repairs, heating installation, and making homes responsive to homeowners' or tenants' disabilities. Rural Veterans are older and more frequently disabled compared with their urban counterparts, which has important implications for VHA healthcare and Veterans' ability to age in place.

Enhance collaboration with government and community-based partners to tap into available but lesser known services and resources

- Mr. Corwin spoke about the housing support programs that are available through the U.S. Department of Agriculture, including grants and loans that can be used to repair substandard housing and government or non-profit facilities or to purchase housing. A reduction in staff has made marketing these resources a challenge; partnering with other government agencies, advocacy groups, and community providers is critical.

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PARTICIPANT BIOGRAPHIES

Debra Baker, LMHC is the Program Director for the Blue Mountain Action Council's SSVF Program located in Walla Walla, Washington. This is a rural program serving 15 counties in Washington, Idaho, and Oregon. The program has five small offices located throughout their service area which covers the footprint of the Jonathon M. Wainwright Memorial VA Medical Center. Debbie is a Licensed Mental Health Counselor who for many years maintained a private practice in the Boston area. Upon her husband's retirement, she moved back home with him to the Pacific Northwest. She is a Veteran of the U.S. Army Military Police Corps, doing her tour right out of high school in 1973, and was stationed in Germany.

Roger Casey, PhD, LSCW is the Director of Education and Dissemination for VA's National Center on Homelessness among Veterans. He has worked with VA homeless programs since 1986, providing direct services, implementing national pilot programs, and developing research initiatives regarding practice-informed residential treatment, housing, and case management design models.

David Corwin is Housing Programs Director for the U.S. Department of Agriculture's Rural Development program in Pennsylvania. In this capacity he oversees program assistance that has averaged over $750 million annually since his tenure began in 2013. David earned a Bachelor of Science in Management Science with a concentration in economics and finance from Lock Haven University of Pennsylvania. His career with USDA Rural Development began in 2009 in Kalispell, Montana as an area specialist working mainly in housing programs. Previous experience included work as a general manager and buyer for a retail furniture wholesaler, a middle school teacher, a musician, and the operator of a mortgage brokerage.

Keith Harris, PhD is a clinical psychologist who serves as National Director of Clinical Operations in the VHA Homeless Program Office. In this role he directs over 4,000 employees providing outreach, case management, vocational services, residential housing, and permanent supportive housing to more than 200,000 homeless Veterans each year. Dr. Harris oversees performance measurement, statistical modeling, and operational planning within VA homeless program services, and is responsible for ensuring quality, effectiveness, and efficiency across programs and sites. He also serves as a VA national leader in Federal and nonprofit interagency efforts to end Veteran homelessness, including the recent 25 Cities Initiative and Built for Zero.

Thomas Klobucar, PhD is the Acting Executive Director for the VHA Office of Rural Health. Appointed to his current position in December 2016, Dr. Klobucar came to VHA in 2010 as a Telehealth Research Associate. A retired Air Force Senior Master Sergeant, he finished his career as an Arms Control Inspector/Interpreter working on the Intermediate Nuclear Forces (INF) Treaty of 1987. Dr. Klobucar has held appointments at the University of Iowa College of Public Health and the Iowa State University Department of Political Science. He is published in the fields of rural health, home telehealth, political science, Soviet studies, sociology, and research methods.

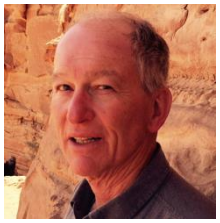
Stephen Metraux, PhD is a researcher at the VA National Center on Homelessness among Veterans. His research involves projects that assess the risk factors for homelessness among Veterans returning from Iraq and Afghanistan, looking at the correlates of homelessness and other outcomes among Veterans after release from jail, and how aging and mortality-related issues impact homeless Veterans. Along with his work at the VA, Dr. Metraux has done extensive research on homelessness and housing, mental illness and community integration, prison reentry, and other aspects of urban health.

Kathryn Monet is the Chief Executive Officer of the National Coalition for Homeless Veterans where she focuses on executing NCHV's strategic policy and technical assistance agenda, and expanding strategic partnerships to more effectively end Veteran homelessness. Kathryn has spent over eight years in the public and nonprofit sectors working to address housing instability and homelessness among Veterans. Prior to joining NCHV, she was with the National Alliance to End Homelessness focusing on the promotion of data-driven, evidence-based interventions to end homelessness, particularly among Veterans. Kathryn also was involved in Veteran homelessness in a legislative capacity during her time at the Senate Committee on Veterans' Affairs. She earned a Masters of Public Administration from Villanova University and a B.S. in Diplomacy and International Relations from Seton Hall University.

Ann Elizabeth Montgomery, PhD is a researcher with the VA National Center on Homelessness among Veterans; a Health Science Specialist with Birmingham VAMC Health Services Research & Development, and an Assistant Professor at the University of Alabama at Birmingham, School of Public Health, Department of Health Behavior. Her work—including research, evaluation, and policy analysis—informs programs and policies at the national level and focuses on several substantive areas including identifying homelessness and risk among Veterans seeking healthcare, assessing interventions intended to mitigate this risk, and studying vulnerable populations and related health disparities.

Linda Southcott is the Deputy Director for the VA Supportive Services for Veteran Families (SSVF) Program. She was a key contributor to the implementation of SSVF in 2011, providing leadership in administrative and operational aspects of program oversight. Ms. Southcott serves as advisor to the SSVF National Director and supports the dissemination of national policies, regulations, and effective practices to community agencies operating SSVF programs throughout the U.S., as well as VA partners and various stakeholders. Prior to joining VA, Linda led strategic planning and grants management efforts within local government for community and workforce development, affordable housing, and homelessness programs.

Dorota Szymkowiak, PhD is a researcher with the National Center on Homelessness among Veterans, based in Philadelphia. Her work consists primarily of secondary analyses of large administrative databases, including the Homeless Operations Management System (HOMES) and VHA electronic medical records. She works principally on operations projects, including ones focused on persistent super-utilization of acute care among homeless Veterans, predictors of eviction from VA's permanent supportive housing, correlates of homelessness among justice-involved Veterans, and patterns of VHA Homeless Programs utilization.



Alan West, PhD is a Health Scientist with the Research Service at the White River Junction, Vermont VAMC, and lead for the Office of Rural Health's National Rural Studies Team. He has published several research papers on rural-urban disparities in health care access and utilization among VA patients, was principal investigator on two HSR&D grants that involved acquiring non-VA treatment data from several states to compare rural and urban VA enrollees' use of VA and private sector medical care, and was Deputy Director of the Veterans Rural Health Resource Center – Eastern Region for its first five years.